

Policy and Procedure	Date Issued 1/1/2010	Section Wiser Choice	Policy Number QA-10	Page 1
Milwaukee County Behavioral Health Division  SAIL	Date Revised	Subject: Wiser Choice Prior Authorization		

## 1. POLICY:

It is the policy of the Behavioral Health Division (BHD) Wiser Choice that Providers must obtain prior authorization before rendering any service and seeking reimbursement from BHD for a client in the Wiser Choice Program.

## 2. PROCEDURE:

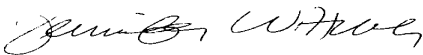
- A. After a client has made an informed choice of Provider, the Central Intake Unit (CIU) staff or Recovery Support Coordinator (RSC) will submit an initial authorization request to the Behavioral Health Division (BHD) for approval. If the request is supported by the information in the comprehensive screen completed by the CIU or the Single Coordinated Care Plan completed by the RSC and if resources are available, BHD will approve the request, thus creating a prior authorization.
- B. Clinical Treatment Providers are required to return the Provider Feedback Form (PFF) to the originating CIU (or Wait List Manager, for wait listed clients) for initial clinical services within:
  - 1 business day after planned appointment, i.e. client showed for treatment, or
  - Within 1 business day if Provider was able to see the client before the scheduled appointment and/or
  - Within 1 business day if 2 weeks pass after the client's initial appointment was made and the client did not present for treatment, i.e. PFF would document that client was a 'no show'. If the client presents after 2 weeks, the Provider must contact the referring CIU and RSC/CMASS to complete the authorization process. This contact needs to be followed by faxing the PFF to the referring CIU.

Failure to return the form within this time frame will result in negating the initial authorization request and denial of payment by BHD. Should the CIU receive your Provider Feedback Form late, your agency will be paid for services beginning the date of receipt of the form. PFF's will not be backdated. **Services provided without prior authorization will not be reimbursed by BHD.**
- C. Authorizations will be for a particular service or group of services and a specific number of units and time period. As units are expended, Providers are required to work with a client's Recovery Support Coordinator and in compliance with the regulations of DHS 75, to determine when to submit a request for additional units of time or change in level of care. BHD will approve or deny these re-authorization requests using the same criteria as initial requests.
- D. It is the Provider's responsibility to submit a request for transfer or extension of service at least 2 weeks, but not more than 3 weeks, before the authorization lapse date or expiration of units, through the RSC agency or to BHD directly if the client does not have an RSC.
  1. The RSC agency will submit a Service Authorization Request (SAR) to BHD within two business days of receiving the ASAM from the clinical treatment provider following the team meeting. If the client has a Case Management and Aftercare Support Specialist (CMASS), the clinical treatment provider will submit the SAR and ASAM directly to BHD.
  2. If the SAR is incomplete or outdated (i.e. the information contained in the SAR is older than 30 days at the time of submission), then BHD shall return the SAR to the RSC agency or the clinical treatment provider for CMASS clients, within three business days of receipt by BHD.

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3. The Provider may contact BHD Administrative Coordination Staff one week prior to the authorization lapse date to inquire about the status of the request.
  4. Failure to follow these timelines may result in a lapsed period of authorization for which services will not be reimbursable.
- E. Emergent/urgent cases in Dimensions 1, 2, or 3 of the ASAM must be referred to the appropriate emergency provider (i.e. detoxification, emergency room, or Psychiatric Crisis Services). Emergent/urgent cases in other Dimensions of the ASAM shall follow the process outlined above in letter "D". The Provider may provide additional clinical supports within the limits of the existing authorization to the client until the SAR is processed and a final determination is rendered.
1. The RSC may request additional ancillary services and notify BHD by writing "Urgent" on the request for ancillary services to mitigate the emergent/urgent needs of the client as the SAR is processed.
- F. Clinical Providers will be notified by BHD of both approvals and denials through the "Authorization View" advisement that is faxed to the Provider the same day a decision is rendered. The Provider has two business days to submit clarifying documentation to the BHD Administrative Coordinator identified on the "Authorization View" advisement. Documentation submitted after two business days will not be considered. BHD will reconsider requests within three business days of receipt of additional documentation and notify the Provider of the final decision through the "Authorization View" advisement. The Provider is not authorized to render new services for reimbursement during the review process.
- G. Ancillary Providers will be notified by BHD of both approvals and denials through the "Authorization View" advisement that is faxed to the Provider the same day a decision is rendered. There is no review process for denials of ancillary services. A SAR may be resubmitted if the updated Single Coordinated Care Plan supports the requested service.

Reviewed & Approved by:



**Jennifer Wittwer, Associate Director  
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